LIVE-IN CARE ATTENDANT CERTIFICATION

TO: (Name and address)
_____
_____
_____

DATE: _____
TELEPHONE #: _____
FAX #: _____

APPLICANT/PARTICIPANT NAME: _____
SOCIAL SECURITY #: _____

FROM:

The individual named directly above is an applicant/tenant of the Federal Housing Tax Credit Program. Federal regulations require that we must verify income in order that the anticipated gross income for the next twelve months may be calculated. The information provided will remain confidential to satisfaction of that stated purpose only. Your prompt response is crucial and would be greatly appreciated.

Sincerely,_____
Project Owner/Management Agent

RETURN THIS FORM TO:

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I duly state the following:

1. I am/will be residing with _____

2. I am ESSENTIAL to the care and well-being of said person.
   Please provide verification of need by said person's health care professional or case manager.

3. I am not obligated or responsible for the financial support of said person.

4. I would not otherwise be living in the unit EXCEPT to provide the necessary supportive care services for said person.

5. I understand that I have no rights to the apartment that will be/is rented to said person. However, I understand that I must abide by the lease agreement signed by the said person. If said person vacates the residence for ANY REASON I will vacate premises as well. I understand that if I would like to occupy an apartment, I will be required to complete the Certification Process on my own record.

I hereby certify that the information provided above is accurate and complete to the best of my knowledge. I consent to release such information in order to comply with government regulations regarding allocation of tax credit housing. I understand that providing false or misleading information under oath may subject me to criminal penalties. I fully understand the information requested and the ramifications of my breach of this agreement.

_____ _____
Signature of Live-In Care Attendant Date

Subscribed and sworn to before me under this _____ day of _____, Year _____

_____
Signature of Notary Public

Notary Public, State of _____ My commission expires _____, Year _____